Application for Long Term Care or Related Medical Assistance

Instructions to the Person Applying for Assistance

Please read all questions carefully before filling out this form and any attached supplements. This information will be used in determining your eligibility and need for assistance. All questions on the form must be completed. If you need help completing or understanding this form, or obtaining social security numbers, contact the Department of Social Service in the county where you live. The form and attachments, when completed and signed by the applicant or authorized representative and witnessed as indicated, should be returned to your local Social Service Office. **All information must be verified. Please attach copies of all verifications.**

For Office Use Only

Case Number Assigned

ID# Assigned

Date received in local office:

This application is for: Long Term Care ____ Assisted Living ____
Adult Foster Care ____ Other _____

Facility Name: _____

1. **Personal Information** (Please Print)

A. Your Name: _____
(First) (Middle) (Last)

B. Current Address: _____
(Nursing Home, Hospital, etc.) (Street) (City) (Zip) (County)
Home Address: _____
(Street) (City) (Zip) (County)

Home Telephone Number (_____) _____–_____

C. Race (can check more than one)
( ) White
( ) American Indian
( ) Black
( ) Hawaiian
( ) Asian

D. Ethnicity
Also check here if Hispanic
( )

E. Sex
Male ( )
Female ( )

F. Current Marital Status
( ) Married ( ) Divorced
( ) Single ( ) Widowed

G. Birth Date
_____ _____ _____
Month Day Year

H. Social Security Number
_____-_____-_____

I. Date of most recent admission to a hospital. Month _____ Day _____ Year _____	J. Date of most recent admission to a medical facility or nursing home. Month _____ Day _____ Year _____

K. How many months have you or someone else paid private rate for your continuous care in any facility? _____ months

L. Are you a resident of South Dakota? Yes ( ) No ( )
Have you applied for or received assistance from South Dakota in the past? Yes ( ) No ( )
If yes, in what county? _____

M. Medicare Claim Number	N. Civil Service Annuity #	O. Railroad Retirement #
P. Veterans Benefit No. Name of Veteran	Q. Do you have Medicare Part A? Yes ( ) No ( ) Part B? Yes ( ) No ( ) Part D? Yes ( ) No ( ) Part D Plan: _____	

* Completion of race, social security numbers (SSN) and citizenship is optional for person not requesting assistance.

2. **Spouse** (If ever married, please answer the questions) A. Full Name of Spouse _____ Address of Spouse _____ _____	B. Birth Date _____ _____ _____ Month Day Year C. If deceased, date of death _____ _____ _____ Month Day Year D. If divorced, date of divorce _____ _____ _____ Month Day Year

E. Social Security Number	F. Medicare Claim Number	G. Civil Service Annuity No.
H. Railroad Retirement Number	I. Is/was your spouse a Veteran? Yes ( ) No ( )	J. Veterans Benefit Number

3. **Dependents**

A. If you have dependent children living in your home, complete the questions below.

Child's Name	Date of Birth	Social Security Number

B. Dependent's Gross Income:

Source _____ Source _____

Amount _____ Amount _____

Frequency _____ Frequency_____

4. **Living Arrangements**

A. Do you or your spouse have shelter costs? (See examples below) Yes ( ) No ( )
If yes, specify type and amount of expenses below. All shelter costs must be verified.

Type of Expense	Amount of Payment	Other
Mortgage	$	Balance due:
Taxes	$	How often paid?
Insurance	$	How often paid?
Rent	$	How often paid?
Utilities [ ] Heating [ ] Electricity [ ] Air Conditioning	$ _____ $ _____ $ _____	

B. Does anyone pay food or shelter costs for you or give you money to pay these costs?
Yes ( ) No ( )

Type of Expense	Amount of Payment	Who Pays
	$	
	$	

5. **Medical** A. Name and address of your primary physician.

_____

_____

_____

B. Do you have any unpaid medical bills from the past three months?
( ) Hospital ( ) Dr Visit
( ) Pharmacy ( ) Other
Names & addresses of facility:

_____

_____

_____

C. Are you requesting assistance for any of the last three months? Yes ( ) No ( )
If yes, for what months?
_____

D. If requesting because of alleged disability, name disability and amount of time disability is expected to last.

_____

6. **Legal Guardian/Power of Attorney**

Do you have a legal (court-appointed) guardian? Yes ( ) No ( )

Do you have a Power of Attorney? Yes ( ) No ( )

Name and address of this person _____

_____

_____

Telephone number_____

Date of guardianship or Power of Attorney (Month & Year) _____

Please provide a copy of document unless previously provided.

7. If you are completing this form for another person give:

Your Full Name (Print) _____

Address _____

_____

Telephone (_____) _____

Your Title or Relationship to Applicant ( ) Family_____
( ) Social Worker ( ) Case Worker ( ) Other _____

Name & address of applicant's relative or friend who may be contacted for information:

_____

Telephone (_____)

8. Name of Facility Caseworker:_____

Resources/Assets Complete questions below for yourself and your spouse.

(Include all your resources/assets, and those owned by your spouse or owned jointly with anyone.)

(NOTE: YOU ARE REQUIRED TO VERIFY ALL OF THE FOLLOWING INFORMATION)

A. **Cash on hand, savings at home, or money held by friends/relatives** Yes ( ) No ( )

Description:	Owner(s):	Value: $

B. **Do you have money in a nursing home account?** Yes ( ) No ( )

Current Balance:

C. **Do you or your spouse have checking accounts or money market accounts?** Yes ( ) No ( )

Bank Name & Address:	Owner(s):	Current Balance: $ $ $ $	Account Number: 1. 2. 3. 4.

NOTE: You are required to attach copies of your most recent bank statements

D. **Do you or your spouse have savings accounts?** Yes ( ) No ( )

Bank Name & Address:	Owner(s):	Balance: $ $ $ $	Account #: 1. 2. 3. 4.

E. **Do you or your spouse have health savings accounts established through a bank, credit union, insurance company or employer ?** Yes ( ) No ( )

Describe:	Owner(s):	Total Value: $ $	Name & Address of Institution

F. **Do you or your spouse have certificates of deposit?** Yes ( ) No ( )
When is interest Paid? ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Bank Name & Address:	Owner(s):	Current Value: $ $ $	Certificate #: 1. 2. 3.

G. **Do you or your spouse own U.S. Savings bonds?** Yes ( ) No ( )			
Description:	Owner(s):	Total Value:	Series# Purch. Date: ___ _____ ___ _____ ___ _____ ___ _____

H. **Do you or your spouse have funds such as Keogh, 401K's or IRA's?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $ $ $	Name & Address of Institution

I. **Do you or your spouse have funds in an annuity or any similar plan or legal instrument?** Yes ( ) No ( ) **(Please read annuity disclosure information and information concerning when the State shall be named beneficiary of an annuity provided on page 13.)**			
Describe:	Owner(s):	Total Value: $	Purchase Date:

J. **Have you or your spouse ever been named in any trust?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Trustee Name:

K. **Do you or your spouse have municipal/corporate/government bonds?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Name & Address of Institution

L. **Do you or your spouse have stocks or mutual funds?** Yes ( ) No ( )			
Describe:	Owner(s):	Total Value: $	Name & Address of Institution

M. **Do you or your spouse have a safety deposit box?** Yes ( ) No ( )		
Location:	Owner(s):	List Contents:

N. **Do you or your spouse own a home?** Yes ( ) No ( )			
Location:	Owner(s):	Who lives in the home Amount owed on home? $_____	
O. **Do you or your spouse own real property (land, city lots, etc.)?** Yes ( ) No ( )			
Is this property rented? Yes ( ) No ( )	Owner(s):	Value: $	County Located:
P. **Do you or your spouse own any buildings or property rights (including mineral or timber rights)?** Yes ( ) No ( )			
Where? (County & State)		Owner(s):	Value: $	Description:
Q. **Do you or your spouse retain a life estate in any property?** Yes ( ) No ( )			
Owner(s) of property	County Location:	Property Value: $	Legal Description:
R. **Do you or your spouse have real property held in trust by the U.S. Government (ie: lease land)?** Yes ( ) No ( )			
Tribe of Enrollment: County:		Enrollment Number:	Yearly Lease Income: $	IIM Account No.:
S. **Do you or your spouse own business equipment, machinery, livestock, antiques, or collections other than household furnishings?** Yes ( ) No ( )			
Please List _____ _____ _____ _____ _____ _____			Value: $ $ $ $ $ $

T. **Have you or your spouse sold property on a contract for deed?** Yes ( ) No ( )

Balance Due on Contract:	Owner(s) of property:	Description of Property:
$_____		

U. **Do you or your spouse have ownership in licensed or unlicensed cars, trucks, motorcycles, boats, recreational vehicles (camper, snowmobile), or any other vehicle?** Yes ( ) No ( ) If yes, complete below.

Owner's First and Last Name:	Co-owner's First and Last Name:	Amount Owed:
Year, Type, Make and Model of Vehicle:	Primary Use of Vehicle:	Value: $
Owner's First and Last Name:	Co-owner's First and Last Name:	Amount Owed:
Year, Type, Make and Model of Vehicle:	Primary Use of Vehicle:	Value: $

V. **Do you or your spouse have life insurance policies?** Yes ( ) No ( )
If yes, list all policies:

Policy No.	Name of Company	Address	Policy Owner	Face Value	Cash Value

W. **Do you or your spouse have any financial arrangements such as contracts, insurance, or accounts designated for burial?** Yes ( ) No ( ) **If yes, list below.**

Applicant	Spouse
Where?_____	Where?_____
_____	_____
Face Value _____	Face Value_____
Does the interest stay in this account? Yes ( ) No ( ) If no, is the interest paid to you? Yes ( ) No ( )	Does the interest stay in this account? Yes ( ) No ( ) If no, is the interest paid to you? Yes ( ) No ( )

9. **Property/Assets In Trust Or Transferred**

Please read statement regarding transfers on page 13 for complete information on look back period.

A. **In the last thirty-six months have you, your spouse, or anyone on behalf of you or your spouse, transferred, given away, gifted, loaned, or deeded sole or joint ownership in anything of value, such as money, land buildings, etc.?**
Yes ( ) No ( ) If yes, complete below.

1. Item transferred, given away, gifted, loaned, or deeded:_____
Date of transactions(s): Month _____ _ Year _____ _____
Cash Value at time of transfer: $ _____
What did you receive in return: _____
_____

2. Item transferred, given away, gifted, loaned, or deeded:_____
Date of transactions(s): Month _____ _ Year _____ _____
Cash Value at time of transfer: $ _____
What did you receive in return: _____
_____

3. Item transferred, given away, gifted, loaned, or deeded:_____
Date of transactions(s): Month _____ _ Year _____ _____
Cash Value at time of transfer: $ _____
What did you receive in return: _____

B. **In the last 36 months have you, your spouse, or anyone established a joint ownership in any real property owned by either you or your spouse?** Yes ( ) No ( ) If yes, complete below.

1. Date of Joint Ownership:_____Type of property: _____ _
Name of Joint Owner: _____Address of Joint Owner: _____

2. Date of Joint Ownership:_____Type of property: _____ _
Name of Joint Owner: _____Address of Joint Owner: _____

C. **In the last 36 months has a joint owner taken possession of their share in any of your or your spouse's asset such as money, savings accounts, checking accounts, certificates of deposits, bonds, stocks, or anything else of value?** Yes ( ) No ( ) If yes, complete below.

1. Date joint owner took possession of their share: Month___Day___Year _____
List the type of asset:_____
Name of joint owner:_____Address of joint owner:_____

2. Date joint owner took possession of their share: Month___Day___Year _____
List the type of asset:_____
Name of joint owner:_____Address of joint owner:_____

D. **In the last sixty months were any of your, your spouse's funds, or property placed in trust for you, your spouse, or anyone else?** Yes ( ) No ( )
If yes, complete below.

1. Date Established:_____ Value:_____
   Name of Trustee:_____ Address of Trustee:_____
   _____

2. Date Established:_____ Value:_____
   Name of Trustee:_____ Address of Trustee:_____
   _____

E. **In the last 36 months has any payment from a trust (either income or principal) become unavailable to you _____or your spouse?** Yes ( ) No ( )
If yes, complete the following:

Date payment stopped or ceased to be available: Month____Day___Year_____
Name of Trustee: _____Address of Trustee:_____

F. **Is any of your income paid directly into a trust?** Yes ( ) No ( )
If yes, complete below:

Date trust was established. Month _____Day _____Year_____
Name of Trustee: _____Address of Trustee:_____

10. **Health Insurance/Long Term Care Insurance**

A. **Do you or your spouse have any health insurance coverage**? Yes ( ) No ( )
If yes, complete below for each person insured.

Insurance Company Name & Add.	Policy Number	Type of Coverage	Premium Amount
_____ _____	_____	☐ Inpatient Hospital ☐ Outpatient ☐ Dental ☐ Cancer ☐ Medicare Supplement ☐ Other (i.e. prescriptions, Workman's Comp.)	Paid: $ _____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Employer Name (if group insurance) _____
Name of Insured _____ Policy Holder Name _____	Group Number _____ Policy Began ___/___/___		

Insurance Company Name & Add.	Policy Number	Type of Coverage	Premium Amount
_____ _____	_____	☐ Inpatient Hospital ☐ Outpatient ☐ Dental ☐ Cancer ☐ Medicare Supplement ☐ Other (i.e. prescriptions, Workman's Comp.)	Paid: $ _____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Employer Name (if group insurance) _____
Name of Insured _____ Policy Holder Name _____	Group Number _____ Policy Began ___/___/___		

B. **Do you or your spouse have any Long Term Care Insurance**? Yes ( ) No ( )
If yes, complete below for each person insured.

Company & Address	Policy #	Person Insured	Premium Amount
_____ _____ _____ _____	_____ _____ Partnership Plan? Yes ( ) No ( )		Paid: $_____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
Company & Address	Policy #	Person Insured	Premium Amount
_____ _____ _____ _____	_____ _____ Partnership Plan? Yes ( ) No ( )		Paid: $_____ ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

10.**Income** (List all income and benefits that you or your spouse receive from any source.)

Please provide proof of all income received.		Direct Deposit x	List amount of income. If not received monthly, indicate how often.	
			You	Your Spouse
A. Social Security Check	Yes ( ) No ( )			
B. SSI (Supplemental Security Income)	Yes ( ) No ( )			
C. Veterans Benefits	Yes ( ) No ( )			
D. Veterans Compensation	Yes ( ) No ( )			
E. Railroad Retirement	Yes ( ) No ( )			
F. Civil Service Annuity	Yes ( ) No ( )			
G. Other Pension If yes, list name, address, & acct #	Yes ( ) No ( )			
H. Annuities	Yes ( ) No ( )			
I. Trusts	Yes ( ) No ( )			
J. Insurance Payments	Yes ( ) No ( )			
K. IRA/KEOGH Payments	Yes ( ) No ( )			
L. Interest Income (on bonds, bank acct's, CD's etc.)	Yes ( ) No ( )			
M. Lease Income	Yes ( ) No ( )			
N. Rental Income	Yes ( ) No ( )			
O. BIA General Assistance	Yes ( ) No ( )			
Q. Tribal Income	Yes ( ) No ( )			
R. Payments on Contract for Deed	Yes ( ) No ( )			
S. Contributions from Relatives or Others	Yes ( ) No ( )			

Please provide proof of all income received.		Direct Deposit X	List amount of income. If not received monthly, indicate how often.	
			You	Your Spouse
R. Gross Earnings from Employment	Yes ( ) No ( )			
S. Child Support Payments	Yes ( ) No ( )			
T. Alimony Payments	Yes ( ) No ( )			
U. Income from Mineral or Timber Rights	Yes ( ) No ( )			
V. Income from Life Estate	Yes ( ) No ( )			
W. Any Other Income	Yes ( ) No ( )			

12. **Certification of Citizenship or Alien Status**

Effective July 1, 2006, Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6036 requires individuals to provide satisfactory documentary evidence of citizenship or nationality, and, if not a citizen or national of the United States, that the individual is in a satisfactory immigration status when initially applying for Medicaid or upon a recipient's first Medicaid re-determination.

Any person who refuses or chooses not to provide information about their citizenship or alien status will not be eligible for benefits, however the individual may be required to answer questions and submit verifications about his or her income/resources, etc. The individual's information may affect the eligibility and/or benefit level of the applicant or recipient of medical assistance. EXCEPTION: Emergency medical assistance may be available to otherwise eligible individuals regardless of their citizenship, immigration status, or having a Social Security Number.

Name on Birth Certificate	Status*	Place of Birth (City and State)

*List status of each person such as: Citizen, Lawful Alien, Student, Visa, etc.

ASSIGNMENT OF MEDICAL SUPPORT, INSURANCE PROCEEDS

An application for and acceptance of medical assistance paid from the Department of Social Services shall operate as an assignment and subrogation of any rights to medical support, insurance proceeds, or both that the applicant or recipient may have. Any rights or amounts so assigned or subrogated shall be applied against the cost of the applicant's or recipient's care

DISCLOSURE OF ANNUITIES AND STATE TO BE NAMED AS REMAINDER BENEFICIARY

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6012 requires individuals applying for long-term care medical assistance and an individual whose eligibility is being reviewed for purposes of determining whether the individual continues to be eligible for long-term care assistance to disclose the description of any interest the individual or the individual's spouse has in an annuity or similar financial instrument. Failure to disclose this information results in ineligibility for assistance. In addition, by virtue of receipt of long term care assistance, the department shall be named as a preferred remainder beneficiary of any interest the individual or individual's spouse has in an annuity or similar financial instrument purchased and owned after February 7, 2006. **Note: The annuity will also be considered a potential resource**.

TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE

Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6011 requires the department to use the following look back periods when determining whether an asset was transferred for less than fair market value.

If the asset was transferred before February 8, 2006, the look back period extends back to 36 months before the first day an individual is institutionalized and applies for long-term care assistance. However, if the asset was transferred to a trust or similar legal device, the look back period extends back 60 months.

If the asset was transferred after February 7, 2006, the look-back period for all transfers extends back to the date 60 months before the first day an individual is institutionalized and applies for long-term care assistance. Because this applies to assets transferred after Feb. 7, 2006, asking for all transfers in the last 36 months catches all transfers that occur during this look-back period until 2009.

ESTATE RECOVERY AND MEDICAL ASSISTANCE LIENS

Under Federal and State law, the Department of Social Services is authorized to make recovery from the estates of deceased medical assistance recipients, who were permanently institutionalized or who were at least 55 years of age and for whom the Department made a payment for nursing facility services; intermediate care facility services for the mentally retarded; other medical institutional services, home and community based services; hospital services; and prescription drug services. The Department of Social Services is authorized to recover the debt of a medical assistance recipient from the estate of a surviving spouse. If a surviving spouse wishes to limit the amount of the surviving spouse's estate that will be liable for recovery for the amount of medical assistance paid on behalf of the recipient, the surviving spouse must file a petition within six months of the death of the medical assistance recipient. The petition will determine the amount of the surviving spouse's estate from which recovery may be claimed for Medicaid expended on behalf of the applicant indicated below. The petition must be filed on the Department's form.

Under Federal and State law, the Department of Social Services may impose a medical assistance lien against real property owned by a recipient who has received a benefit from the Department of Social Services for the services of a nursing facility, an intermediate care facility for the mentally retarded, or other medical institution. The Department of Social Services will issue a separate notice when the Department decides to impose a lien. The notice will describe the amount of the lien and the real property to which the lien is to attach.

Under State law, the Department of Social Services is authorized to recover any funds of the resident kept or maintained by the home or other facility if the resident was receiving medical assistance from the Department at the time of death.

Privacy Act Statement

Federal and State Law Regulations limit the use and disclosure of confidential information concerning applicants and recipients of economic and medical assistance programs to purposes directly related to the administration of those programs. When you apply for assistance from the Department of Social Services, you will be asked to provide your Social Security Number on the application form. Title 42 of the Code of Federal Regulations Part 435.910(a), requires the furnishing of Social Security Numbers as a condition of eligibility for Medicaid. The Department uses your number in its computer processing for eligibility determination, welfare fraud investigations and audits. Social Security Numbers are also used to verify income information, through agencies such as Internal Revenue Service, Department of Labor, and Social Security Administration, etc. to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in benefits easier to implement and to determine the accuracy and reliability of information given to the department by applicants for and recipients of assistance.

Verifications

Information you give to answer the questions on this form, and information obtained by the department to verify your answers will be used to determine your eligibility and level of benefits. Your benefits may change from month to month, or be stopped, based on this information.

Federal and state officials will verify information given on this form to determine if it is correct. A department representative may contact you or may contact other people in order to verify your eligibility for assistance. Information given will also be verified by computer cross-matching with other agencies and private sectors. When state and federal personnel verify the information on this application, if what is reported is found to be incorrect your Medical case may be denied or terminated and you may be subject to criminal prosecution for knowingly providing false information.

Authorization to Furnish Information and Release Information

I hereby authorize any person, agency or institution to supply information requested by the Department of Social Services concerning me or my family, and to allow inspection and reproduction of records in his or their possession pertaining to me or my family by any duly authorized representative of the Department. I further authorize the Department to release such information to providers or cooperating State or Federal Agencies.

This authorization is given only in connection with its use by the Department in the administration of its programs and for no other purpose. It shall continue in effect until such time as I state in writing that it is no longer valid.

I herewith release any person, agency or institution from any and all liability to me or my family for supplying such information.

Civil Rights Guarantee

The provisions of the Civil Rights Act of 1964, as amended, also apply to your case and department representatives shall not, on the grounds of race, color, creed, religion, sex, disability, ancestry, or national origin, exclude you from participation in, deny the benefits of, or otherwise subject you to discrimination under any program or activity administered by the department. Any person who feels that his civil rights have been violated may request a fair hearing. You may also file a complaint of discrimination by writing DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or by calling (605) 773-3305.

Acknowledgement

I understand that any false statements which I may make and any failure on my part to report any change in circumstance which would affect my eligibility for payment from programs administered by the South Dakota Department of Social Services constitutes a crime and that I could be prosecuted under South Dakota criminal laws.

I agree to provide information upon request from the Department of Social Services concerning any asset or estate which may be subject to recovery, estate recovery, or medical assistance liens by the State of South Dakota.

SIGNATURES

Applicant should sign the application unless incapacitated or represented by a Legal (Court Appointed) Guardian. A representative, who can make health related decisions, may sign the application on behalf of the incapacitated or deceased applicant. The applicant's mark should be witnessed by a person familiar with the applicant.

Signature of Applicant or Recipient	Date	Signature of Spouse	Date
Witness to Applicant's mark	Date	Signature of Legal Guardian or Power of Attorney	Date
Name of Individual Assisting Applicant	Date	Signature of Individual Assisting Applicant	Date